DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 2

2. STATE: New Mexico

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 (a) as amended

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4-19-B pages ~~7 and 7a~~
See attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See attachment

10. SUBJECT OF AMENDMENT:

Establishment of a new prospective payment methodology based on Section 1902 (aa) for Rural Health Clinics and Federally Qualified Health Centers

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Medicaid Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kathleen Vaudt for RMaruca

13. TYPED NAME:
Robert T. Maruca

14. TITLE:
Director, Medical Assistance Division

15. DATE SUBMITTED:
May 30, 2001

16. RETURN TO:
Robert T. Maruca, Director
Medical Assistance Division
P. O. Box 2348
Santa Fe, New Mexico 87504-2348

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
31 MAY 2001

18. DATE APPROVED:
1 JUNE 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 JANUARY 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Calvin G. Cline

21. TYPED NAME:
CALVIN G. CLINE

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID AND STATE OPERATIONS

23. REMARKS: Pen & ink changes made per state's request.

New Mexico TN 01-02, HCFA-179

Block 8	Block 9
Page 7	Page 7, TN 96-04
Page 7a	Page 7a, TN 90-09
Page 7b	New
Page 7c	New
Page 7d	New
Page 7e	New

VI. For laboratory services, payment does not exceed maximum levels allowed by the Title XVIII carrier.

VII. Payment for dental prostheses is made using the same methodology for professional services as outlined in Section I of this attachment.

Payment for durable medical equipment and prosthetic and orthotic appliances is made at the lesser of the provider's billed charge or the current Medicare fee schedule when a fee schedule amount is available.

Effective January 1, 1996, when a Medicare fee schedule amount is not available durable medical equipment is reimbursed at the actual acquisition cost plus 25 percent when the actual acquisition cost is less than $1,000. When the actual acquisition cost is $1,000 or more, reimbursement is limited to actual acquisition cost plus 15 percent.

Payment for parenteral and enteral nutrition products is made at amounts which do not exceed those paid by Medicare.

Payment for glasses is made at invoice cost for materials subject to a limit on reimbursement for frames. This limit, as well as payment for dispensing eye glasses, is made at a level established by the Department which considers payment practices of other third party organizations, negotiations with appropriate professional societies, and the usual charges of the providers for services to non-Medicaid patients.

STATE New Mexico
DATE REC'D 3-5-01
DATE APPV'D 6-12-01
DATE EFF 1-1-01
HCFA 179 NM 01-02

A

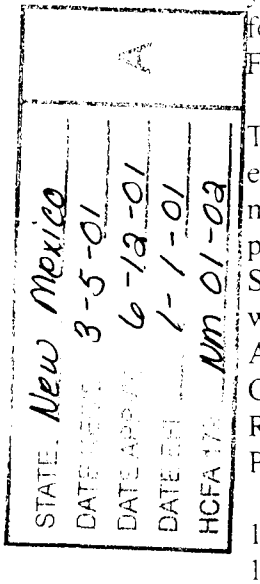
SUPERSEDES: TN- 96-04

VIII. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

a. Reimbursement- FQHCs and RHCs must submit claims for reimbursement on the UB-92 claim form or its successor. Once enrolled, providers receive instructions on documentation, billing, and claims processing. Interim and final reimbursement for FQHC and RHC services are made by the Medical Assistance Division (MAD) based on submitted claims. Effective January 1, 2001, FQHCs and RHCs will be reimbursed under a prospective payment system (PPS) that conforms to the provisions of the Benefits Improvement and Protection Act (BIPA) 2000.

b. Interim PPS rate for FQHCs and RHCs:
FQHCs and RHCs will receive an interim payment rate during the transition to the PPS. The interim rate will be the rate in effect December 31, 2000, updated in accordance with the FQHC and RHC payment regulations in effect on December 31, 2000. These rates are facility specific and will remain in force until such time as the PPS base period rate for each FQHC and RHC has been established. This interim rate will be inflated by the Medicare Economic Index (MEI) each October 1st, starting with Federal Fiscal Year 2002.

c. Base Rates for the Prospective Payment System (PPS):
Once FQHC and RHC cost reports filed for periods ending in calendar years 1999 and 2000 are finalized, the PPS base rates will be established for each FQHC and RHC. The PPS base rate per encounter for each FQHC and RHC will be calculated as follows:



The allowable cost per encounter from cost reports filed for periods ending in calendar years 1999 and 2000 will be indexed (inflated) from the mid-point of the cost reporting period to the mid-point of the base rate period. The base rate period will be from January 1, 2001, through September 30, 2001. The simple average rate from these two cost reports will be the PPS base rate.

An Example of the Base Period Rate Calculation Follows:

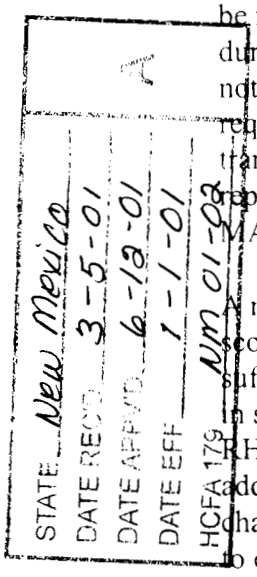
Cost Report Period	Allowable Cost Per Encounter	MEI Inflation	Inflated Cost
1/99 – 12/99	$ 120.00	6%	$ 127.20
1/00 – 12/00	$ 125.00	4%	$ 130.00

Encounter Simple Average (Base Period Rate) $ 128.60

Once the base period rate for each FQHC and RHC has been calculated, any claims paid for dates of service on or after January 1, 2001, that were paid an interim rate, will be reprocessed. This reprocessing will adjust the payment on each claim to the PPS base rate amount.

d. Updates to PPS base rates:
Beginning in Federal Fiscal Year (FFY) 2002, and each year thereafter, each FQHC and RHC payment amount (on a per visit basis) will be increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services. This adjustment to the PPS rate will be effective each October 1.

e. Change in Scope of Services
Once the PPS rates are determined as outlined in this section, adjustments to those rates to reflect changes in the scope of services will be made upon the written request of the provider and approval by MAD. A provider's request for a PPS rate adjustment due to a change in scope of service must be received no later than 90 days after the provider's fiscal year end during which the change in scope of service occurred. The provider should notify MAD in advance of any impending changes. The provider will be required to submit data supporting that a change in the scope of service transpired. This documentation will include FQHC and RHC information report and any other supporting documentation considered necessary by MAD or its designee.



A minimum of six months should have elapsed since the change in the scope occurred to ensure the change was not temporary and that there is sufficient information upon which to base a rate adjustment. If the change in scope of service occurred in the last six months of a FQHC's and RHC's fiscal period, MAD may require the FQHC and RHC to submit an additional information report, covering at least six months since the change in scope of service transpired, to obtain the information necessary to evaluate the request.

MAD and/or its designee will review the request and determine if an adjustment to the established PPS rate is merited. The following criteria will be used to evaluate each FQHC request for a rate adjustment due to a change in scope of service. MAD's final determination will be communicated to the FQHC and RHC in writing.

1. MAD or its designee will evaluate each request for a rate revision due to a change in scope of service. If it is determined that a significant change in the scope of service has occurred, the reasonable incremental cost per encounter from this change will be added to the PPS rate and a new rate established. This new rate will be effective on the date the change in scope of service was implemented. If it is determined that a significant change in the scope of service has not transpired, no adjustment will be made to the encounter rate.

2. The events that could create a change in the scope of services are defined to include, but are not limited to, such things as significant expansion or remodeling of an existing clinic, the opening of an additional satellite clinic (new site), addition of new services, deletion of existing services, or other changes in the scope/intensity of services offered by a clinic that significantly increase or decrease the clinic's costs, relative to its PPS rate. A change in scope of services will not be considered to have transpired unless it increases or decreases a FQHC's and RHC's cost per encounter by more than 2.5%.

f. Managed Care Wrap-Around Payments:
MAD will pay a supplemental 'wrap-around' payment for managed care organization (MCO) encounters. FQHCs and RHCs must submit invoices, on a regular basis (at least quarterly), but no more frequently than monthly, which identify the number of encounters per each MCO. Supporting documentation must be provided upon request.

1. Interim Wrap-Around Payment Percentages:
MAD will pay a percentage of the FQHCs and RHCs PPS rate as the wrap-around payment. MAD will determine this payment percentage, with input from its designee and from each FQHC and RHC. MAD's determination will be communicated to each FQHC in writing. Wrap-around payments will be made directly by MAD, not as a pass through from the managed care entity.

Final Settlement of MCO Encounters:
On an annual basis MCO encounters will be settled. This process will be done to reconcile MCO encounter payments to the PPS rate(s). To perform this reconciliation total payments due will be calculated by multiplying MCO encounters by the PPS rate(s). MCO payments and Interim Wrap-Around payments received during the period will then be subtracted from the total amount due. Any over or under payment

The reports could be used to assist in the evaluation of a change in scope of service, to assist in setting the initial PPS rate for a new FQHC and RHC, and for other purposes.